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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NATIVIDAD G. OLEGARIO AKA** **NATIVIDAD GACUSANA OLEGARIO** **2014 Cameron Court** **Barstow, CA 92311** **Registered Nurse License No. 566881** Respondent.	Case No. 2010-598 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 17, 2000, the Board of Registered Nursing issued Registered Nurse License Number 566881 to Natividad G. Olegario aka Natividad Gacusana Olegario (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

REGULATORY PROVISIONS

6. Section 2761 of the Code states:

> "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. California Code of Regulations, title 16, section 1442, states:

> "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

10. California Code of Regulations, title 22, section 72311 states as follows:

"(a) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(2) Implementing of each patient's care plan according to the methods

indicated. Each patient's care shall be based on this plan.

(3) Notifying the attending licensed healthcare practitioner acting within the scope of his or her professional licensure promptly of:

(A) The admission of a patient.

(B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.

(C) An unusual occurrence, as provided in Section 72541, involving a patient.

* * * *

(E) Any untoward response or reaction by a patient to a medication or treatment.

(F) Any error in the administration of a medication or treatment to a patient which is life threatening and presents a risk to the patient.

(G) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient.

(b) All attempts to notify licensed healthcare practitioners acting within the scope of his or her professional licensure shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any. If the attending licensed healthcare practitioner acting within the scope of his or her professional licensure or his or her designee is not readily available, emergency medical care shall be provided as outlined in Section 72301(g)."

11. 42 Code of Federal Regulations (CFR), section 483.20(b), sets forth the following guidelines:

"(b) Comprehensive assessment -- (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State.

* * * *

(k) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following --

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25.

(3) The services provided or arranged by the facility must –

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care."

12. 42 CFR, section 483.25 states, in pertinent part, as follows:

"Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to --

* * * *

(iv) Eat"

COST RECOVERY PROVISION

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

SUMMARY OF FACTS

Patient F.T.

14. Patient F.T. was an 83-year-old resident of Rimrock Villa Convalescent Hospital (RVCH), 27555 Rimrock Road, Barstow, CA 92311, during the time period relevant to this action. On or about January 15, 2004, Respondent was hired as the Director of Nursing (DON) at RVCH. As DON, among other things, Respondent directed the overall operation of the nursing services department to ensure the highest degree of quality resident care in accordance with all laws and regulations. In addition, the DON was required to attend and participate in care plan meetings, was ultimately responsible for ensuring the formulation of nursing diagnoses; that appropriate patient care plans were timely developed, updated and followed by the nursing staff; and for ensuring that a patient's care plan was set forth in the patient's hospital records; and that the care plan and 24-hour log were read and followed by the nursing staff.

15. On or about June 22, 2005, Patient F.T. choked on some bread. The Heimlich maneuver was successfully applied, and she was placed on a pureed diet on June 23, 2005, until a speech evaluation could be completed. A resident care conference review for Patient F.T. was conducted, and a speech evaluation was ordered for her. On June 27, 2005, a swallowing evaluation by a therapist revealed that Patient F.T. had "mild dysphagia" (difficulty swallowing), but it was not felt that her problem was significant enough to require swallowing therapy. The therapist recommended a regular diet with staff reminding Patient F.T. to take small bites of food, especially bread items, and to alternate between eating the food and swallowing liquids. The therapist also recommended that the patient sit upright during her meals. The physician ordered a "regular texture, thin liquids" diet for Patient F.T., and to encourage "small bites, alternate food and liquid swallows."

16. Respondent did not develop or implement a specific care plan to address Patient F.T.'s choking incident of June 22, 2005 or her mild dysphagia, as recommended by the therapist and ordered by the physician. There was no written "stand alone" document entitled "plan of care", nor did any of the records of Patient F.T. indicate that it was ordered that the nursing staff place her in an upright position to eat. Moreover, Patient F.T.'s records were not updated sufficiently to reflect that the nursing staff was aware of its revised responsibilities to keep Patient F.T. safe after her choking incident. Respondent's signature for attendance is not on the form regarding attendance at care conference meetings for Patient F.T., subsequent to her first choking incident.

17. On or about January 19, 2006 at 9:00 p.m. a certified nurse assistant (CNA) gave Patient F.T. a peanut butter and jelly sandwich. The CNA did not remind her to take small bites alternating with food, nor did she place her in an upright position. The CNA only told her "Remember, you promised you gonna eat." Patient F.T. was alert, was lying in bed at an approximate 30 degree angle, and had a cup of water by her bed. At 9:10 p.m., the Charge Nurse found Patient F.T. to be non-responsive, initiated CPR, and paramedics were called. The paramedics found chewed food particles in Patient F.T.'s throat, thought to be parts of the sandwich she was given as a bedtime snack. On January 19, 2006, at approximately 10:17 p.m.,

Patient F.T. was pronounced dead at the acute facility. The Death Certificate lists "choking on food" as the immediate cause of death.

18. The California Department of Health Services (DHS) investigated the circumstances surrounding Patient F.T.'s death, and issued a statement of deficiencies and plan of correction and a Class "AA" Citation to RVCH in the amount of $65,000, on or about June 1, 2006. During the DHS investigation, in response to a question about whether a plan of care had been developed for Patient F.T. after the first choking episode, Respondent replied "I think we missed that." During an interview with Respondent and the Administrator, the Administrator indicated "I can't find the care plan" (for Patient F.T.). The DHS determined that RVCH failed to develop a plan of care for Patient F.T. that incorporated interventions to prevent her from choking on her food again.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) on the grounds of unprofessional conduct, in that Respondent committed acts of gross negligence, within the meaning of California Code of Regulations, title 16, sections 1442 and 1443.5, and title 22, section 72311, and 42 CFR, section 483.20, subsections (b), (k), (i) and (3)(i), and section 483.25, subdivisions (a)(1)(iv). The circumstances are as described in Paragraphs 14-18 above, which are incorporated herein by reference, and include an extreme departure from the accepted standard of practice of a registered nurse in that there was a failure to implement an adequate written plan of care for Patient F.T., so that precautions were taken to prevent her from choking on her food.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

20. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) on the grounds of unprofessional conduct, in that Respondent committed acts of incompetence, within the meaning of California Code of Regulations, title 16, sections 1442, 1443 and 1443.5 and title 22, section 72311, and 42 CFR, section 483.20, (b), (k), (i) and (3)(i), and section

483.25, subdivisions (a)(1)(iv), involving the treatment of Patient F.T, as described in Paragraphs 14-19 above, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

21. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) on the grounds of unprofessional conduct, in that Respondent committed acts of gross negligence and incompetence, within the meaning of California Code of Regulations, title 16, sections 1442, 1443 and 1443.5 and title 22, section 72311, 42 CFR, section 483.20, (b), (k), (i) and (3)(i), and section 483.25, subdivisions (a)(1)(iv), involving the treatment of Patient F.T, as described in Paragraphs 14-20 above, which are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 566881, issued to Natividad G. Olegario aka Natividad Gacusana Olegario.

2. Ordering Natividad G. Olegario aka Natividad Gacusana Olegario to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/17/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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